because they dared to quietly celebrate their faith. I speak as much for them today as I do in protest to the brutal killing of their fellow-believer.

This hour, I call on the Government of Iran to ensure the safety of these individuals. Better yet, I call for the release of these individuals whose only crime was the sincere expression of their faith, which happens to be a minority religion. Most importantly, I call upon the government of Iran to provide freedom of religion to its people, including the famously peaceful yet brutalized Baha'is community.

I want to take this opportunity to commend the international community for its swift response to Mr. Rowhani's execution and urge other governments and organizations to vigilantly monitor the fate of the 15 jailed Baha'is, particularly the 3 jailed in Mashad presently facing the death penalty.

Religious persecution demands a tireless counter response; it demands a vigilant defense. If we hold the principle of religious freedom to be a precious and fundamental right, something worth protecting, then we must always defend those who are wrongfully and brutally crushed for their faith by hostile national governments.

We cannot bring Mr. Rowhani back or right the wrong that was done to him and his family, but we can advocate against this happening again. Iran must abide by global human rights principles. Accordingly, Iran must release the fifteen Bahai who have been incarcerated for their faith. Iran must preserve the lives of those facing execution for their faith. Iran must honor its commitment to the religious freedom principles of the Universal Declaration of Human Rights and set these prisoners free.●

NURSING SCHOOL ADMINISTERED PRIMARY CARE CLINICS

● Mr. INOUYE. Mr. President, I rise today to speak on an health issue of great importance now and in future years. As our population continues to increase, our elderly live longer, and healthcare technology advances, the need for access to care will undoubtedly also increase.

Because of these monumental increases in the need for healthcare access for many Americans, I wish to take a few minutes to discuss the need for support of nursing school administered primary care centers.

Nursing centers are university or nonprofit entity primary care centers developed (primarily) in collaboration with university schools of nursing and the communities they serve. These centers are staffed by faculty and staff who are public health nurses and nurse practitioners. Students supplement patient care while receiving preceptorships provided by colleges of nursing faculty and primary care physicians, often associated with academic institutions, who serve as collaborators with nurse practitioners.

Nurse practitioners, and public health nurses, in particular, are educated through programs which offer advanced academic and clinical experiences, with a strong emphasis on primary and preventive health care. In fact, schools of nursing that have established these primary health care centers blend service and education goals, resulting in considerable benefit to the community at large.

Nursing centers are rooted in health care models established in the early part of the 20th century. Lillian Wald in the Henry Street Settlement and Margaret Sanger, who opened the first birth control clinic, provided the earliest models of service.

Since the late 1970's, in conjunction with the development of educational programs for nurse practitioners, college of nursing faculties have established nursing centers. There are currently 250 centers nationwide, affiliated with universities and colleges of nursing in Arizona, Utah, Pennsylvania, South Carolina, Tennessee, Texas, Hawaii, Virginia, and New York. The Regional Nursing Centers Consortium, an association of eighteen nursing centers in New Jersey, Pennsylvania and Delaware, was established in 1996 to foster greater recognition of, and support for, nursing centers in their pursuit of providing quality care to underserved populations.

Nursing centers tend to be located in or near areas with a shortage of health professionals or areas that are medically underserved. The beneficiaries of their services have traditionally been the underserved and those least likely to engage in ongoing health care services for themselves or their family members. In the 1970's, I sponsored legislation that would give nurses the right to reimbursement for independent nursing services, under various federal healthcare programs. At the same time, one of the first academic nursing centers was delivering primary care services in Arizona.

As the Vice Chairman of the Committee on Indian Affairs, I am pleased to note that the University of South Carolina College of Nursing has established a Primary Care Tribal Practice Clinic, under contract with the Catawba Indian nation, which provides primary and preventive services to those populations. The University also has a Women's Health Clinic and Student Health Clinic, which are both managed by nurse practitioners.

Another prime example of services provided by nurse practitioners is the Utah Wendover Clinic. This clinic, in existence since 1994, provides interdisciplinary rural primary health services to more than 10,000 patients annually. The clinic now has telehealth capabilities that provide interactive links from the clinic to the university hospital, 120 miles away. This technology allows practitioners direct access to medical support for primary care, pediatrics, mental health, potential abuse, and emergency trauma treatment.

To date, nursing centers have demonstrated quality outcomes which, when compared to conventional primary health care, indicate that their comprehensive models of care have resulted in significantly fewer emergency room visits, fewer hospital inpatient days, and less use of specialists. The Lasalle Neighborhood Nursing Center, for example, reported for 1997 that fewer than 0.02 percent of their primary care clients reported hospitalization for asthma; fewer than 4 percent of expectant mothers who enrolled delivered low birth rate infants; 90 percent of infants and young children were immunized on time; 50 percent fewer emergency room visits; and the clinic achieved a 97 percent patient satisfaction rate.

What makes the concept of nurse managed practices exciting and promising for the 21st century is their ability to provide care in a ''spirit of serving'' to underserved people in desperate need of health care services. Interestingly, nurse practitioners have consistently provided Medicaid sponsored primary care in urban and rural communities for a number of years, and have consistently demonstrated their commitment to these underserved areas.

The 1997 Balanced Budget Act (P.L. 105–33) included a provision that for the first time ever allowed for direct Medicare reimbursement of all nurse practitioners and clinical nurse specialists, regardless of the setting in which services were performed. This provision built upon previous legislation that allowed direct reimbursement to individual nurse practitioners for services provided in rural health clinics throughout America. The law effectively paved the way for an array of clinical practice arrangements for these providers; however, per visit payments to nurse run centers, as opposed to individual practitioners, was not formally included in the law.

Federal law now also mandates independent reimbursement for nurse practitioners under the Civilian Health and Medical Programs of Uniformed Services (CHAMPUS), the Federal Employee Health Benefits Plan (FEHBP) and in Department of Defense Medical Treatment Facilities.

As the Ranking Member of the Defense Appropriations Subcommittee, my distinguished colleagues and I have listened to the testimonies of the three Service Chief Nurses each year, during the Defense Medical hearings. I am proud to report that the military services have taken the lead in ensuring the advancement of the profession of nursing. Military advanced practice nurses provide care to service members and their families at all of the treatment facilities. The Graduate School of Nursing at the Uniformed University of the Health Sciences (USUHS), which has a very successful nurse practitioner program, was recently recognized in the top 100 graduate schools in the United States. The Commanding General at Tripler Army Medical Center, a two star position, is a nurse. This

is a first ever accomplishment for nurses in the military. I hope to see more nurse officers in these leadership roles, even at the three star level.

At the beginning of this session of Congress, I proposed legislation to amend Title XIX of the Social Security Act to expressly provide for coverage of services by nursing school administered centers under state Medicaid programs, similiar to payments provided to rural health clinics. Today, as we debate a number of health care issues, I urge us to consider creative avenues for expanding health care access for all Americans, particularly the poor and underserved. Nursing centers, as new models of health care providers, offer quality services for lower payments.

In closing, I would like to reiterate that nurse practitioners provide cost effective, preventive care in underserved areas across America. Their educational programs emphasize the provision of care to patients with limited resources, financial and otherwise. A recent article in U.S. News and World Report showcased the successful Columbia Advanced Practice Nurse Associates (CAPNA), a nurse run primary care clinic in New York City. Dr. Mary Mundinger, the Dean of the Columbia School of Nursing and a Robert Wood Johnson Health Policy Fellow in 1984, was the catalyst for the center, which she envisions as a ''prototype of a new branch of primary care.''

Nurse practitioners have proven themselves to be well trained providers of high quality, cost effective care.

Nursing school administered centers offer viable alternatives to health care access for the poor and underserved, and allow Americans more choices in their selection of cost effective, quality care services. The issues surrounding quality, access and the provision of patient care services are, Mr. President, at the crux of our current debates over health care reform. We owe it to each and every American to provide the very best options for quality health care available.

Mr. President, I thank you for the opportunity to address my colleagues on this most important topic. I ask that an article on this subject be printed in the RECORD.

The article follows:

[From the U.S. News & World Report, July 27, 1998]

FOR NURSES, A BARRIER BROKEN—IT'S A TEST INSURERS ARE BACKING: CAN PRIMARY CARE WORK WITHOUT DOCTORS?

(By James Lardner)

Seems like everybody's been trying to take a bite out of doctors' paychecks lately—the federal government, employers, insurers, and now, of all people, nurses. In New York City, Medicare and eight private health plans have given their enrollees permission to get primary care from a group of nurse practitioners or NPs, who diagnose, treat, prescribe, refer, and bill very much as if they were M.D.'s.

About 250 New Yorkers have signed up with the 10-month-old practice, known as CAPNA (for Columbia Advanced Practice Nurse Associates), and though it's still a tiny operation—just four NPs—business is growing by six or seven new patients a week. Supporters think the idea of a nurse-run form of primary care has a lot of potential. Many doctors are dubious.

The New York State Medical Society's chief lobbyist, Anthony Santomauro, sees a threat to the well-being of physicians as well as of patients. ''Your action,'' Santomauro warned his colleagues recently, ''could decide whether nurse practitioners . . . continue to serve under your direction and supervision or . . . become independent practitioners in direct competition.'' To Robert Graham, executive vice president of the American Academy of Family Physicians, what the nurses are doing ''comes very close to practicing medicine, which of course, requires a medical degree and a license.''

The law aside, critics argue that primary care entails subtle diagnostic decisions that physicians are uniquely qualified to make. ''The four years in medical school and three years in residency training and many hours of continuing education that physicians receive are very different from the 500 to 700 hours of training that most nurse-practitioner programs call for,'' says Nancy Dickey, a Texas physician who recently became president of the American Medical Association. (There are roughly 140,000 nurses with advanced degrees in the United States; as a rule, NPs have master's degrees that entail two years of classroom and clinical training.)

While physicians stress the possibility of confusion about who is or isn't an M.D., they may be up against a bigger problem: a widespread longing for a slower-paced, more personal form of health care than many people feel they can get from physicians these days. ''If you spend 10 minutes with a doctor in New York City, you're doing well,'' says Doris Ward, a 77-year-old former nonprofit executive. Ward came to CAPNA's offices on East 60th Street seeking treatment for high cholesterol and anxious to find ''someone who would sit down and talk to me for a little while.'' Her NP, Marlene McHugh, devoted an hour to the initial appointment and recommended a dietary rather than a medical approach to her problem.

Thomas Becker, a 36-year-old marketing manager, was confused about whom he was seeing. He didn't know that Edwidge Thomas was not a doctor when he picked her from a list supplied by his health plan; in fact, he didn't realize his mistake until his first visit. But Thomas asked such insightful questions that ''it didn't really matter to me,'' Becker says. After three appointments, two for sports-related injuries and one for flu, he rates CAPNA ''absolutely excellent.''

Bedside manner. Mary O'Neil Mundinger, dean of the Columbia University School of Nursing and the driving force behind CAPNA, sees it as the prototype of a new branch of primary care. She spent 17 years as a bedside nurse before getting a doctorate in public health, and she dismisses the suggestion that nurses are likely to overlook symptoms or botch diagnoses (''We don't miss things,'' she says crisply). But physicians, she argues, overemphasize diagnosing and prescribing, and tend to consider their work over once they have recommended a program of treatment; nurses, she says, are better at getting patients to follow the program.

Two studies seem to bolster her case. Nurse practitioners have long provided primary care to those who might otherwise have gone unserved, such as residents of rural areas, and a 1986 study by the Office of Technology Assessment concluded that the care they provided was equivalent to that offered by physicians. When it came to communication and prevention, the OTA found NPs more adept.

In addition, a 1993 analysis of studies comparing care offered by physicians with that provided by NPs found that nurses spent about 25 minutes with a patient; doctors spent 17. The two groups were about equal in their rates of prescribing drugs, but the nurses provided more patient education and stressed exercise more often than the doctors.

While the debate may seem to pit nurses against doctors, the more important division exposed by CAPNA may be between two types of physician, primary-care providers and specialists. Critics of the CAPNA model fear that NPs, because they have less training than physicians, will rely too much on specialists. Many specialists respond that in the age of managed care, overreferral by nurses is far less of a danger than underreferral by doctors, who are torn between the interests of patients and, as Eric Rose, the chief of surgery at Columbia-Presbyterian Medical Center, puts it, ''the care of their bankbooks and the HMOs' bankbooks.'' (CAPNA has been referring surgery cases to Columbia-Presbyterian.)

CAPNA's acceptance by insurers as a legitimate primary-care alternative to a practice run by physicians is clearly a breakthrough for nurses, who were long defined as hospital workers who existed to do the bidding of physicians. As recently as the 1970s, nursing-school curricula included elaborate protocols of respect (surrendering one's chair, for example) that a nurse was supposed to follow when a physician entered a room.

The power of physicians is also under attack from market-oriented critics, who see them as attempting to carve out a monopoly at the consumer's expense. In the past, physicians' organizations have used their clout to beat back proposals to give quasi-medical powers to nonphysicians. But CAPNA was created with no change in the law; Mundinger reasoned that the kind of health care she hoped to offer affluent patients in midtown Manhattan was already the norm in much of rural and inner-city America. New York itself allowed NPs to write prescriptions—otherwise, health care in many areas of the state would have ground to a halt. ''As long as it was just poor folks, nobody was paying any attention,'' Mundinger says.

The groundwork was laid in 1993, when Columbia-Presbyterian sought the nursing school's help in expanding health care services in two poor, upper-Manhattan neighborhoods. Spotting an opportunity, Mundinger asked in return for something that earlier partnerships of nurse practitioners had lacked: hospital admitting privileges—the ability to get patients into Columbia-Presbyterian and supervise their care there. Two new primary-care practices were created, one with doctors and nurse practitioners working as equals, the other run entirely by NPs.

Mundinger's next brainstorm was to see if the concept would work in an affluent neighborhood. This time, in a move with widespread implications for health care, she went after managed-care plans for the right of reimbursement.

Equal treatment. For the HMOs—under constant pressure from employers to cut costs—a nurse-run practice had obvious appeal if it meant lower payments for the same services. But Mundinger rejected support that was conditioned on reduced reimbursement, insisting that would open the HMOs to the charge of chiseling and cast her practice as a cheap substitute for real medicine. After months of discussions, Oxford Health Plans agreed to go along. Seven more health plans followed suit, all giving the nurses the same fee-for-service rates as doctors.

Mundinger's admirers say she has not only created a significant new model of health

care but, in doing so, has called the medical profession's bluff. Say Uwe Reinhardt, a health economist who teaches at Princeton University, ''Doctors always say the are rugged individualists, for free enterprise and such, and now at the first sight of a nurse they run to the government and say, 'Please use your coercive powers to protect us!' ''

Even some supporters, however, fear that Mundinger's model, for all its noble objectives, will appeal to the basest motives of insurers and employers, leaving patients, in the end, with less-trained people who are in just as much of a hurry. There is some reason for doubting this: A study in the April Nurse Practitioner, for example, found NPs more consistent than gynecologists in adhering to medical standards in evaluating cervical dysplasia, a precursor to cervical cancer. And as Robert Brook, a Rand analyst who is conducting an internal assessment for CAPNA, puts it: ''It's not like we started out with a perfect system.●''

TRIBUTE TO LIEUTENANT COLONEL KEVIN ''SPANKY″ KIRSCH, USAF

Mr. WARNER. Mr. President, I rise today to pay tribute to Lieutenant Colonel Kevin ''Spanky'' Kirsch, United States Air Force, on the occasion of his retirement after over twenty years of exemplary service to our nation. Colonel Kirsch's strong commitment to excellence will leave a lasting impact on the vitality of our nation's military procurement and information technology capabilities. His expertise in these areas will be sorely missed by his colleagues both in the Pentagon and on Capitol Hill.

Before embarking on his Air Force career, Colonel Kirsch worked as an estimator/engineer for Penfield Electric Co. in upstate New York, where he designed and built electrical and mechanical systems for commercial construction. In 1978, Colonel Kirsch received his commission through the Officer Training School at Lackland AFB in San Antonio, TX. Eagerly traveling to Williams AFB in Arizona for flight training, Colonel Kirsch earned his pilot wings after successful training in T–37 and T–38 aircraft.

In 1980, Colonel Kirsch was assigned to Carswell AFB, in Fort Worth, TX, as a co-pilot in the B–52D aircraft. While serving in this capacity on nuclear alert for the next five years, he earned his Masters degree, completed Squadron Officer School and Marine Corps Command and Staff School by correspondence, and earned an engineering specialty code with the Civil Engineering Squadron.

An experienced bomber pilot serving with the 7th Bomb Wing, Colonel Kirsch, then a First Lieutenant, served as the Resource Manager for the Director of Operations—a position normally filled by an officer much more senior in rank. He was selected to the Standardization Evaluation (Stan-Eval) Division and became dual-qualified in the B–52H. Subsequently, he was selected ahead of his peers to be an aircraft commander in the B–52H.

Colonel Kirsch was selected in 1985 as one of the top 1% of the Air Force's captains to participate in the Air Staff Training (ASTRA) program at the Pentagon. His experience during that tour, working in Air Force contracting and legislative affairs, would serve him well in later assignments.

In 1986, Colonel Kirsch returned to flying in the FB–111 aircraft at Plattsburgh AFB, NY. He joined the 529th Bomb Squadron as an aircraft commander and was designated a flight commander shortly thereafter. He employed his computer skills to help automate the scheduling functions at the 380th Bomb Wing and was soon designated chief of bomber scheduling.

Following his tour with the 529th, Colonel Kirsch was assigned to Strategic Air Command (SAC) Headquarters at Offutt AFB, NE. As Chief of the Advanced Weapons Concepts Branch, he served as a liaison with the Department of Energy on nuclear weapons programs and worked on development of new strategic systems—including the B–2 bomber. Colonel Kirsch was one of four officers chosen to be part of the commander-in-chief's (CINC's) staff group to facilitate the transition of SAC to Strategic Command (STRATCOM). Originally picked as a technical advisor for weapon systems, he soon became the legislative liaison for STRATCOM. In this capacity, Colonel Kirsch organized congressional delegations to visit STRATCOM, and managed CINC STRATCOM's interaction with Capitol Hill.

In 1994, Col Kirsch traveled here, to Washington, to begin his final assighment on active duty. Initially serving as a military assistant to the Assistant Secretary of Defense for Legislative Affairs, Colonel Kirsch once again quickly distinguished himself and was designated the special assistant for acquisition and C3 policy. Representing the Secretary of Defense, the Under Secretary of Defense for Acquisition and Technology and the Assistant Secretary of Defense for C3I, Colonel Kirsch managed a myriad of critical initiatives including acquisition reform and information assurance. He also served as the principal architect for the organization's web page, computer network, and many of the custom applications used to automate the office's administrative functions.

Colonel Kirsch's numerous military awards include the Defense Superior Service Medal, the Defense Meritorious Service Medal with Oak Leaf Cluster, the Air Force Meritorious Service Medal, the Air Force Commendation Medal with Oak Leaf Cluster, and the Air Force Achievement Award.

Following his retirement, Colonel Kirsch and his wife Carol will continue to reside in Springfield, VA with their children Alicia and Benjamin.

Mr President, our nation, the Department of Defense, the United States Air Force, and Lieutenant Colonel Kirsch's family can truly be proud of this outstanding officer's many accomplishments. His honorable service will be genuinely missed in the Department of Defense and on Capitol Hill. I wish Lieutenant Colonel Spanky Kirsch the very best in all his future endeavors.

D.A.R.E. MICHIGAN OFFICER OF THE YEAR 1998

● Mr. ABRAHAM. Mr. President, I rise today to recognize Officer Kimberly Sivyer of the Redford Township Police Department. He has been named the D.A.R.E. Officer of the Year for 1998 in the state of Michigan.

Officer Sivyer started with the Redford Police Department in 1981. He has dedicated his time and service to D.A.R.E. since 1990. Over the course of these eight years he has touched many students' lives educating them about the dangers of drugs and violence. He has and continues to be an excellent role model for the youth of his community. His colleagues at the Redford Township Police Department and the members of his community recognize this and it is for these reasons that he is very deserving of this award.

I want to once again express my sincerest appreciation and congratulations to Officer Sivyer for being named D.A.R.E. Officer of the Year 1998. He should be very proud of this achievement.●

THE COUNTRY OF GEORGIA

● Mr. BROWNBACK. Mr. President, I would like to say a few words about Georgia and the recent events which have taken place in this impressive country. Several days ago, Georgia reaffirmed its commitment to full participatory democracy when the Minister of State requested the resignation of all cabinet ministers, and then resigned himself. His resignation was accepted, and President Eduard Shevardnadze has vowed to reconstitute a new government by the middle of August. This transition, so reminiscent of the ebb and flow of governments in great parliamentary democracies, has been accomplished without violence or bloodshed, without chaos or confusion, and with the support of the Georgian people. Truly Georgia is an inspiration to peoples everywhere who long for democracy and who struggle against the freedom-stifling legacy of the communist experiment.

Georgia is impressive in other ways as well. Its economy continues to grow in a positive direction, unlike the economies of some of its neighbors; Georgia is not perfect, and it is not pristine. But it is progressive. With a growth rate of nearly 8 percent in 1997 and projected growth of 11–13 percent in 1998, Georgia is on track to a significant economic turn-around.

This turn-around and the prosperity that will inevitably flow from it, still involve many hurdles. Georgians have bravely faced these challenges, and they face more still. Probably none is so painful as the ongoing conflict in Abkhazia, Georgia's most northwestern province bordering Russia. This brutal